#### **BEFORE THE BOARD OF REGISTERED NURSING** DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:

SUMMER LORRAINE JENSEN-TOFT a.k.a. SUMMER LORRAINE JENSEN, SUMMER LORRAINE BLEUR, SUMMER LORRAINE TOFT 22632 Formentor Mission Viejo, CA 92691

Registered Nurse License No. 604446

Respondent.

Case No. 2006-243

OAH No. L-200670399

#### **DECISION AND ORDER**

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, as its Decision in this matter.

> This Decision shall become effective on October 4, 2007. It is so ORDERED September 4,2007.
>
> La Francine White

FOR THE BOARD OF REGISTERED NURSING

	1			
1	EDMUND G. BROWN JR., Attorney General of the State of California			
2	MARGARET ANN LAFKO, Supervising Deputy Attorney General			
3	LORETTA A. WEST, State Bar No. 149294 Deputy Attorney General			
4	California Department of Justice			
5	110 West "A" Street, Suite 1100 San Diego, CA 92101			
6	1.0. Box 05200			
7	San Diego, CA 92186-5266 Telephone: (619) 645-2107			
8	Facsimile: (619) 645-2061			
9	Attorneys for Complainant			
10				
11	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA			
12				
13				
14				
15	In the Matter of the First Amended Accusation	Case No. 2006-243		
16	Against:	OAH No. L-200670399		
17	SUMMER LORRAINE JENSEN-TOFT a.k.a. SUMMER LORRAINE JENSEN,	STIPULATED SURRENDER OF		
18	SUMMER LORRAINE BLEUR, SUMMER LORRAINE TOFT	LICENSE AND ORDER		
19	22632 Formentor Mission Viejo, CA			
20	92691			
21	Registered Nurse License No. 604446			
22	Respondent.			
23				
24				
25	In the interest of a prompt and speedy re	esolution of this matter, consistent with the		
26	public interest and the responsibility of the Board of Registered Nursing (Board), the parties			
27	hereby agree to the following Stipulated Surrender of License and Order which will be submitted			
28	to the Board for approval and adoption as the final disposition of the First Amended Accusation.			
ļ				

#### **PARTIES**

- 1. Ruth Ann Terry, M.P.H, R.N (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Loretta A. West, Deputy Attorney General.
- 2. SUMMER LORRAINE JENSEN-TOFT (Respondent) is represented in this proceeding by attorney Donald B. Brown, whose address is 3848 Carson Street, Suite 206, Torrance, California 90503.
- 3. On or about August 14, 2002, the Board of Registered Nursing issued Registered Nurse License No. 604446 to SUMMER LORRAINE JENSEN-TOFT (Respondent). The License was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 2006-243 and will expire on March 31, 2006, unless renewed.

#### **JURISDICTION**

4. Accusation No. 2006-243 was filed before the Board of Registered Nursing and served on Respondent, with all other statutorily required documents, on June 9, 2006. Respondent timely filed her Notice of Defense contesting the Accusation. First Amended Accusation No. 2006-243 was filed before the Board of Registered Nursing and superceded Accusation No. 2006-243. First Amended Accusation No. 2006-243 was served on Respondent, with all other statutorily required documents, on April 27, 2007, and is currently pending against Respondent. A copy of First Amended Accusation No. 2006-243 is attached as exhibit A and incorporated herein by reference.

#### ADVISEMENT AND WAIVERS

- 5. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in First Amended Accusation No. 2006-243.
  Respondent also has carefully read, discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Order.
- 6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to

confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

#### **CULPABILITY**

- 8. Respondent admits the truth of each and every charge and allegation in the First Amended Accusation No. 2006-243, agrees that cause exists for discipline and hereby surrenders her Registered Nurse License No. 604446 for the Board of Registered Nursing's formal acceptance.
- 9. Respondent understands that by signing this stipulation she enables the Board of Registered Nursing's Order accepting the surrender of her Registered Nurse License No. 604446 without further process.

#### **RESERVATION**

10. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board of Registered Nursing or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

#### **OTHER MATTERS**

- 11. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.
- 12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board of Registered Nursing may, without further notice or formal proceeding, issue and enter the following Order:

1///

#### **ORDER**

IT IS HEREBY ORDERED that Registered Nurse License No. 604446, issued to Respondent SUMMER LORRAINE JENSEN-TOFT is surrendered and accepted by the Board of Registered Nursing.

- 13. The surrender of Respondent's Registered Nursing License and the acceptance of the surrendered license by the Board of Registered Nursing shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.
- 14. Respondent shall lose all rights and privileges as a Registered Nurse (R.N.) in California as of the effective date of the Board of Registered Nursing's Decision and Order.
- 15. Respondent shall cause to be delivered to the Board of Registered

  Nursing's both her wall license and pocket license certificate on or before the effective date of the

  Decision and Order.
- application for licensure or a petition for reinstatement in the State of California, the Board of Registered Nursing shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in the First Amended Accusation No. 2006-243 shall be deemed to be true, correct and admitted by Respondent when the Board of Registered Nursing determines whether to grant or deny the petition.
- 17. Should Respondent ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation, No. 2006-243 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.
- 18. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

3107920691 BROWN & BROWN (949) 215-7279 p.3 Summer Jensen-Toft May 10 06 02:04a PAGE 07/18 BROWN & BROWN 3107928691 04/27/2007 15:28 NO.939 Deat. of Justice + 913107922691 GH/27/2987 16:02 Respondent shall pay the Board its costs of investigation and enforcement 19. 1 in the amount of \$8,590.00 (eight thousand five hundred dollars) prior to havence of a new or 2 remetered license. 3 ACCEPTANCE I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Donald B. Brown. I understand the stipulation and the б effect it will have on my Registered Nursing License. I enter into this Stipulated Surrender of 7 License and Order volumently, knowingly, and intelligently, and agree to be bound by the 8 Decision and Order of the Board of Registered Nursing. 9 APR 2 7 2007 DATED: 10 SUMMER LORISATIVE JENSER 11 12 13 I have read and fully discussed with Respondent SUMMER LORRAINE 14 JENSEN-TOFT the terms and conditions and other matters contained in this Stipulated 15 Surrender of License and Order. I approve its John and 16 DATED: APR 2 7 2007 17 18 may for Respondent 19 20 ENDORSEMENT The foregoing Stipulated Surrender of License and Order is hereby respectfully 21 submitted for consideration by the Board of Registered Nursing. 22 23 EDMUND G. BROWN JR., Attorney General DATED: of the State of California 24

25

LOREITA A. WEST Deputy Attorney General

26 27

Attorneys for Complainmit

28 DOJ MINISTER 10: 5202004101592

30129347.-mpd

1	19. Respondent shall pay the Board its costs of investigation and enforcement			
2	in the amount of \$8,500.00 (eight thousand five hundred dollars) prior to issuance of a new or			
3	reinstated license.			
4	<u>ACCEPTANCE</u>			
5	I have carefully read the above Stipulated Surrender of License and Order and			
6	have fully discussed it with my attorney, Donald B. Brown. I understand the stipulation and the			
7	effect it will have on my Registered Nursing License. I enter into this Stipulated Surrender of			
8	License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the			
9	Decision and Order of the Board of Registered Nursing.			
10	DATED:			
11				
12	SUMMER LORRAINE JENSEN-TOFT Respondent			
13				
14	I have read and fully discussed with Respondent SUMMER LORRAINE			
15	JENSEN-TOFT the terms and conditions and other matters contained in this Stipulated			
16				
17	DATED:			
18	DONALD B. BROWN			
19	Attorney for Respondent			
20				
21	<u>ENDORSEMENT</u>			
22	The foregoing Stipulated Surrender of License and Order is hereby respectfully			
23	submitted for consideration by the Board of Registered Nursing.			
24	DATED: <u>5/9/07</u> EDMUND G. BROWN JR., Attorney General			
25	of the State of California			
26	Loute A. West			
27	Deputy Attorney General			
28	Attorneys for Complainant			
	DOJ Matter ID: SD2004801533 80129347.wpd			

# Exhibit A First Amended Accusation No. 2006-243

ľ					
1	EDMUND G. BROWN Jr., Attorney General				
2	of the State of California MARGARET ANN LAFKO				
3	Lead Supervising Deputy Attorney General LORETTA A. WEST, State Bar No. 149294				
4	Deputy Attorney General California Department of Justice				
5	110 West "A" Street, Suite 1100 San Diego, CA 92101				
6	P.O. Box 85266				
7	San Diego, CA 92186-5266				
8	Facsimile: (619) 645-2061				
l	Attorneys for Complainant				
9	BEFORE T				
10	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA				
11	In the Matter of the First Amended Accusation				
12	Against:	Case No. 2006-243			
13	SUMMER LORRAINE JENSEN-TOFT	THE OF A LATENCE TO			
14					
15	SUMMER LORRAINE TOFT 22632 Formentor				
16	Mission Viejo, CA 92691	•			
17	Registered Nurse License No. 604446 Respondent.				
18	Ruth Ann Terry, M.P.H., R.N., Execu	ntive Officer ("Complainant") alleges:			
19	PARTIE	<u>es</u>			
20	1. Complainant brings this Accu	sation solely in her official capacity as the			
21	Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.				
22	2. The original Accusation No. 2006-243, filed on May 26, 2006, is				
23	superceded by this First Amended Accusation No. 2006-243.				
24	License History				
25	3. On or about August 14, 2002,	the Board of Registered Nursing issued			
26	Registered Nurse License Number 604446 to Summer Lorraine Jensen-Toft ("Respondent"), also				
27	known as Summer Lorraine Jensen, Summer Lorraine Bleuer, Summer Lorraine Toft. The				
28	license will expire on March 31, 2008, unless renewed.				

# 

# 

# 

# 

## 

## 

## 

# 

#### 

### 

#### 

#### 

#### 

# 

# 

#### 

### 

## 

#### 

### 

### 

#### **STATUTORY PROVISIONS**

- 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.
- 6. Code section 118, subdivision (b), provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.
  - 7. Code section 2761 states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct, . . .
- (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
- (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.
- (f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.
  - 8. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

- (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
- (c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.
- (d) Be committed or confined by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in subdivision (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the confinement is prima facie evidence of such commitment or confinement.
  - (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

#### **REGULATIONS**

9. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. California Code of Regulations, title 16, section 1444, states:

A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

(c) Theft, dishonesty, fraud, or deceit.

28 /

11. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

#### **COST RECOVERY**

12. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

#### DRUGS

13. "Dilaudid," is a brand name for hydromorphone hydrochloride, is a Schedule II controlled substance under Health and Safety Code section 11055 (b)(1)(k) and a dangerous drug per Business & Professions code section 4022.

#### FIRST CAUSE FOR DISCIPLINE

## (Conviction of Substantially Related Crimes)

subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivisions (a), (b), (c), and (d), in that on or about March 26, 2007, in a criminal proceeding entitled *People vs. Summer Lorraine Jensen-Toft* in Orange County Superior Court, Case Number 06NF4175 FA, Respondent was convicted of three separate felony counts, on her plea of guilty, for violating Penal Code section 11173(a) (Obtaining Controlled Substance by Fraud), a felony, and was sentenced to the following: three (3) years formal probation; ninety (90) days custody in county jail, stayed pending Respondent's participation and completion of a court-approved drug rehabilitation program; Respondent is prohibited from practicing registered nursing for two years or until this Board of Registered Nursing proceeding in Accusation Case No. 2006-243 is completed, whichever occurs first; and, pay \$200.00 restitution fees. The facts and circumstances underlying Respondent's criminal convictions are as follows:

28 | ///

- a. On or about August 2, 2005, at 8:39 a.m., 10:00 a.m., 11:02 a.m., 11:34 a.m., 11:35 a.m., 12:50 p.m., 12:51 p.m., and 2:18 p.m., while on duty as a registered nurse at West Anaheim Medical Center Emergency Department, Respondent removed a total of 10 mcg. of Dilaudid, 1 mcg. each, from her employers' AcuDose machine, without physicians' orders. Respondent documented administering 4 mcg. of Dilaudid, without physician's orders, leaving 6 mcg. of Dilaudid unaccounted for.
- b. On August 2, 2005, at 2:18 p.m., and 3:39 p.m., while on duty as a registered nurse at West Anaheim Medical Center Emergency Department, Respondent removed a total of 4 mcg. of Dilaudid, 1 mcg. each, from her employers' AcuDose machine, without physicians' orders. Respondent made a duplicate entry of wastage of 1 mcg. of Dilaudid on August 2, 2005, at 4:23 p.m. leaving 2 mcg. or 3 mcg. of Dilaudid unaccounted for.
- c. On August 3, 2005, at 12:51 p.m., while on duty as a registered nurse at West Anaheim Medical Center Emergency Department, Respondent removed a total of 4 mcg. of Dilaudid from her employers' AcuDose machine, without physicians' orders, and documented administering 2 mcg. of Dilaudid, without physicians' orders, on August 3, 2005, at 3:40 p.m. leaving 2 mcg. of Dilaudid unaccounted for.
- d. On August 3, 2005, at 12:52 p.m. and 1:10 p.m., while on duty as a registered nurse at West Anaheim Medical Center Emergency Department, Respondent removed a total of 4 mcg. of Dilaudid, 1 mcg. each, from her employers' AcuDose machine, without physicians' orders, and documented she wasted a total of 4 mcg. of Dilaudid at 1:53 p.m. and 2:00 p.m.
- e. On August 3, 2005, at 8:12 a.m., 9:02 a.m., 10:12 a.m., 10:15 a.m., 11:34 a.m., 11:37 a.m., 11:50 a.m., and 12:15 p.m., while on duty as a registered nurse at West Anaheim Medical Center Emergency Department, Respondent removed a total of 16 mcg. of Dilaudid, 2 mcg. each, from her employers' AcuDose machine, without physicians' orders. Respondent did not document administering or wasting any of these 16 mcg., leaving 16 mcg. of Dilaudid unaccounted for.

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

# 

#### 

#### 

#### 

# 

#### **SECOND CAUSE FOR DISCIPLINE**

# (Incorrect and/or Inconsistent Entries in Hospital and/or Patient Records)

- 15. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that on August 2, 2005, and August 3, 2005, while a licensee and on duty at West Anaheim Medical Center Emergency Department, Respondent made grossly incorrect or grossly inconsistent entries in hospital and/or patient records, regarding her removal of Dilaudid from her employers' AcuDose machine, without physicians' orders, as described above in paragraphs 13(a) through 13(e).
- 16. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that between June 17, 2002, and April 4, 2003, while a licensee and employed at Hoag Memorial Hospital, in Newport Beach, California, Respondent made grossly incorrect or grossly inconsistent entries in hospital and/or patient records in the following respects:

#### Patient No. 112-24-24

- a. On February 21, 2003, at 2310 hours, Respondent withdrew 5 mcg. of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. Respondent charted the administration of 3 mcg. of Morphine Sulfate in the patient's Medication Administration Record, and wasted the remaining 2 mcg. of Morphine Sulfate. However, Respondent failed to document the patient's post-administration pain level in the nurse's notes.
- b. On February 22, 2003, at 2358 hours, Respondent withdrew 0.25 mcg. of Xanax, a controlled substance, from the Pyxis machine for this patient. Respondent charted the administration of 0.25 mcg. of Xanax in the patient's Medication Administration Record; however, Respondent failed to adequately document the details of the patient's heart rate in the nurse's notes.

#### Patient No. 032-47-20

c. On February 27, 2003, at 2136 hours, Respondent withdrew 5 mcg. of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. Respondent

charted the administration of 2 mcg. of Morphine Sulfate in the patient's Medication

Administration Record and wasted the remaining 3 mcg. of Morphine Sulfate. However,

Respondent failed to follow the physician's order by administering Morphine Sulfate instead of administering Toradal first, as requested in the order.

- d. On February 28, 2003, at 0156 hours, Respondent withdrew 5 mcg. of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. Respondent charted the administration of 2 mcg. of Morphine Sulfate in the patient's Medication Administration Record and wasted the remaining 3 mcg. of Morphine Sulfate. However, Respondent failed to follow the physician's order, to "try Toradal first," in that Respondent administered the Morphine Sulfate instead of first administering Toradal, as requested in the physician's order. Furthermore, Respondent charted the administration of the Morphine Sulfate to this patient at 0100 hours, almost one hour prior to withdrawing the Morphine Sulfate from the Pyxis machine for this patient.
- e. On February 28, 2003, at 0300 hours, Respondent withdrew 5 mcg. of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. Respondent charted the administration of 2 mcg. of Morphine Sulfate in the patient's Medication Administration Record and wasted the remaining 3 mcg. of Morphine Sulfate. However, Respondent failed to follow the physician's order, to "try Toradal first," in that Respondent administered the Morphine Sulfate instead of first administering Toradal, as requested in the physician's order. The order further stated that the medication was to be given every two hours for pain; however, Respondent administered the last two doses of Morphine Sulfate within one hour of each other, i.e., 0156 hours and 0300 hours. Respondent also failed to document the patient's pre- or post-administration pain level to support the administration of the medication to this patient.
- f. On March 4, at 0155 hours, Respondent withdrew 5 mcg. of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. Respondent charted the administration of 2 mcg. of Morphine Sulfate in the patient's Medication Administration Record and wasted the remaining 3 mcg. of Morphine Sulfate. However, Respondent failed to document

the patient's pre- or post-administration pain level to support the administration of the medication for this patient.

#### Patient No. 112-62-02

- g. On February 28, 2003, at 2049 hours, Respondent removed 100 mcg. of Fentanyl Citrate, a controlled substance, from the Pyxis for this patient. Respondent charted the administration of 50 mcg. of Fentanyl Citrate in the patient's Medication Administration Record and wasted the remaining 50 mcg. of Fentanyl Citrate. However, Respondent failed to document in the nurse's notes the patient's pre- and post-administration pain assessment to support the administration of the medication for this patient.
- h. On February 28, 2003, at 0003 hours Respondent removed 100 mcg. of Fentanyl Citrate, a controlled substance, from the Pyxis for this patient. Respondent charted the administration of 50 mcg. of Fentanyl Citrate in the patient's Medication Administration Record and wasted the remaining 50 mcg. of Fentanyl Citrate. However, Respondent failed to document in the nurse's notes the patient's pre- and post- pain assessment to support the administration of the medication for this patient.

### THIRD CAUSE FOR DISCIPLINE

### (Gross Negligence or Incompetence)

- 17. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, as defined in California Code of Regulations, title 16, section 1443, in that on August 2, 2005, and August 3, 2005, while working as a registered nurse at West Anaheim Medical Center Emergency Department,, Respondent committed acts constituting incompetence or gross negligence, as set forth in paragraphs 13(a) through 13(e), above.
- 18. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, as defined in California Code of Regulations, title 16, section 1443, in that between June 17, 2002, and April 4, 2003, while employed at Hoag Memorial Hospital, in Newport Beach, California, Respondent committed acts constituting incompetence or gross negligence, as set forth in paragraph 15, above.

#### **PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters here	ein
alleged, and that following the hearing, the Board of Registered Nursing issue a decision:	

- 1. Revoking or suspending Registered Nurse License Number 604446 issued to Summer Lorraine Jensen-Toft, aka Summer Lorraine Jensen, Summer Lorraine Bleuer, Summer Lorraine Toft;
- 2. Ordering Summer Lorraine Jensen-Toft, aka Summer Lorraine Jensen, Summer Lorraine Bleuer, Summer Lorraine Toft, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,
  - 3. Taking such other and further action as deemed necessary and proper.

13 DATED: April 27, 2007

RUTH ANN TERRY, M.P.H., R.N.

EXECUTIVE OFFICER

Board of Registered Nursing Department of Consumer Affairs

State of California

Complainant

--

1st Amended Accusation.wpd

SD2004801533